THE ASIAN COLLECTIVE FOR HEALTH SYSTEMS

Health Workforce Migration in Southeast Asia

Regional Dynamics and Global Implications

Developed by

Dr. Neethi V Rao (Fellow, Centre for Social and Economic Progress) based on participant discussions at the Regional Workshop on Human Resources for Health, Co-organized by The Asian Collective for Health System and WHO SEARO in Sri Lanka, 3-5 July 2025

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1. Introduction

International migration of health workers constitutes a fundamental challenge in contemporary global health governance, in the context of a projected 10 million health worker shortage by 2030 (WHO 2016; Eaton et al 2023). This shortage occurs simultaneously with escalating healthcare demands driven by demographic transitions, epidemiological shifts toward non-communicable diseases, and the persistent threat of pandemic and climate emergencies (Scheffler et al 2018; Zodpey et al 2018; GHE WHO 2021). The workforce deficit disproportionately affects low- and middle-income countries (LMICs) while high-income countries (HICs) increasingly rely on international recruitment to address domestic shortages (Scheffler and Arnold 2019; Boniol et al 2022, GHWS WHO 2024). The crisis goes beyond numerical deficits, reflecting structural inequities embedded in the political economy of health professional education and the asymmetric capacities between nations to produce, employ, and retain healthcare workers (Buchan and Catton 2023; Boniol et al 2022).

The maldistribution of health workers globally perpetuates and intensifies existing health inequities, with profound implications for achieving universal health coverage and health system sustainability (GHWS WHO 2024; GHE WHO 2021). The COVID-19 pandemic has both exposed and exacerbated these pre-existing structural inequities in health workforce distribution (Bourgeault et al 2020). While HICs initiated aggressive international recruitment campaigns to address pandemic-induced workforce shortages, source countries confronted the dual challenge of managing their own pandemic responses with depleted workforces while experiencing accelerated emigration of health professionals (Socha-Dietrich & Dumont 2021; Williams et al 2020). Bhutan, for example, witnessed a sharp drop in the availability of nurses, from a density of 23.11 per 10,000 population in 2022 to just above 20 in 2024, even as the overall number of health workers in the country rose (Ministry of Health, Government of Bhutan meeting presentation).

Southeast Asia and South Asia have long been primary source regions, with the Philippines and India leading global nurse and physician exports, respectively (Castro-Palaganas et al 2017; Toyin-Thomas et al 2023). A study conducted in 2020 found about 240,000 Filipino and 90,000 Indian-born nurses practising in OECD countries (Buchan and Catton 2020). In 2017, approximately 69,000 Indian-trained physicians were working in the United States, the United Kingdom, Canada, and Australia, which was about 6.6% of the doctors registered with the Medical Council of India (MCI). In the same year, nearly 56,000 Indian-trained nurses were working in these four countries, which was about 3% of the total registered nurses in India (Walton-Roberts and Rajan 2020). India has become a major source of migrant nurses, and in recent years, the number of Indian nurses registered in the UK, for example, has increased rapidly (Sumption et al 2023). More recently, physicians from Sri Lanka are also actively seeking to emigrate at rates that will be unsustainable for the domestic health system. According to Sri Lanka's President, Ranil Wickremesinghe, in 2024, approximately 30% to 40% of doctors and nurses trained in the country opt to leave. A case study on Sri Lanka is included with this paper to sharply illustrate the complex dynamics between socio-economic factors and health system governance that influence health workers' migration, which were especially accelerated due to the Sri Lankan economic crisis.

The Asian region bears 27% of global disease burden while possessing only 13% of health workers, contrasting sharply with 10 HICs that employ 23% of global health workers while bearing 8% of disease burden (NHWA WHO 2024; GHE WHO 2023). Despite overall improvements, many countries in the region still fall below WHO thresholds for workforce density. The greatest absolute shortages are concentrated in South and Southeast Asia, notably in countries like Bangladesh and Indonesia. On the other hand, countries such as Thailand, Malaysia, and Singapore have developed medical tourism industries that attract foreign patients, while relying on imported health professionals. There are thus instances of both intra-regional migration as well as migration to other affluent regions outside Asia. Governments across South and Southeast Asia are increasingly seeking ways of managing international health workforce migration in ways that minimise risk, especially in times of crises, while amplifying potential gains to national health systems.

2. Objective of the Paper

Recognising this policy priority, the Asian Collective for Health Systems (TACHS), together with the World Health Organisation's South East Asia Regional Office (WHO SEARO), organised a regional meeting of policymakers, experts and practitioners from across the South and Southeast Asian Region. This discussion paper is based on the discussions at this meeting and synthesises perspectives from source and recipient countries in Asia with the objective of identifying regional strategies from Asia to manage international health workforce migration, ethically and sustainably. For the purpose of this paper, health workers refer to doctors and nurses since much of the literature and the data on migration that is available pertains to these two groups of health workers. The discussions at the regional meeting offer a starting point for this paper, which is further elaborated by drawing insights from published literature using targeted searches. The peer-reviewed articles are complemented by reports and datasets published through multilateral sources such as the WHO (health workforce accounts), IOM (remittances, migration rate, etc) and the World Bank (cost of living data), as well as relevant news articles, published post-COVID-19.

The regional meeting included ministry of health officials and regulators, as well as technical experts and practitioners engaged in health workforce policy and planning from 15 countries across the SEAR and WPR regions. The discussions highlighted the inequity in global workforce distribution and the drivers of migration that create these conditions (section 3). Discussions highlighted the multi-dimensional implications of international migration (section 4), while acknowledging the variety of perspectives and policy priorities for countries in the region (section 5). The discussions on managing international workforce migration focused in particular on two aspects. The first was the global code, which is currently being revised with an expert group that was set up to provide recommendations for revision. Members from the expert advisory group were participants at the regional meeting and stimulated a discussion of the various aspects that need to be included as part of such a global instrument, which are summarised in section 6.1. Recognising, however, that the global code cannot address the informal, self-directed migration that often occurs without government intervention, the second part of the discussions focused on potential avenues of South-South cooperation (section 6.2). The complexity of the issue meant that several policy and research questions remained, which are outlined in section 7. Section 8 provides a brief conclusion highlighting the importance and urgency of this issue in global, regional, and national health policy discourses and for achieving the goal of equitable and resilient healthcare access for all.

3. Drivers of Migration

The migration of human resources is propelled by systemic push and pull factors that are embedded in the structural disparities between low- and middle-income source countries and high-income destination countries (Henderson and Tulloch 2008; Ojo et al 2023). Destination countries exert a powerful pull through a combination of economic incentives, professional opportunities, and structured recruitment mechanisms.

Push Factors in Source Countries

- **Wage Differentials and Market Forces for Health Services:** A primary driver is the wage differential between the source and destination countries. A nurse in the Philippines, for instance, may earn a salary that is lower than what is offered for a comparable position in a Gulf state or an OECD nation. The growing privatisation and global orientation of healthcare training systems in some countries also encourage migration, as many training institutions and curricula are explicitly oriented towards preparing professionals for export rather than for domestic retention.
- **Limited Specialisation and Professional Development Opportunities:** Many health workers feel limited by a lack of advanced specialisation options and continued career growth opportunities. Despite growing education capacity, many countries lack sufficient postgraduate training slots, mentorship, and cutting-edge facilities, prompting professionals to seek such opportunities abroad where they are more accessible. In India, for example, the hyper-competitive and numerically restricted postgraduate medical

education system serves as a significant bottleneck, compelling many medical graduates to pursue career pathways outside the country (Aggarwal et al, 2024). Doctors and nurses, who are placed in remote areas, can feel especially disadvantaged with few chances to attend career development programmes that are often organised in big cities (Dissanayake, 2025).

- **Heavy Workloads, Poor Working Conditions, and Skill Drain:** High staff-to-patient ratios, under-resourced hospitals, and rural–urban disparities make working conditions challenging across many countries in the region. The most skilled practitioners are the first to leave, often leaving others to shoulder unsustainable workloads. For instance, in the Philippines, shortages of skilled nurses have even led to hospital closures and critical care gaps in rural areas (Robredo et al 2022). Low per capita health spending and low workforce densities contribute to poor conditions and reinforce migration incentives. The COVID-19 pandemic acutely exposed these vulnerabilities, with widespread reports of shortages of personal protective equipment and systemic burnout across the region, accelerating intentions to emigrate.

Pull Factors in Destination Countries

- **Economic and Professional Incentives:** Destination countries often boast superior infrastructure, advanced technology, funding for continuing education, and better-regulated working environments. Regulations and professional development incentives aimed at retaining talent are often unable to overcome the comparative economic and professional advantages offered by high-income countries (Rao & Schmidt, 2023).
- **Active Recruitment and Streamlined Pathways:** The global health labour market features sophisticated recruitment architecture, with agencies in hubs like Kerala (India) and Manila (Philippines) channelling talent to meet specific demands abroad. Furthermore, well-defined and institutionalised pathways, such as the Commission on Graduates of Foreign Nursing Schools (CGFNS) for Filipino nurses targeting the US market, have created a predictable and reliable pipeline. Many destination countries also provide health professionals and their families with pathways to permanent residency or citizenship. This long-term stability, with better access to education, healthcare, and social services for dependents, can be a powerful motivator.
- **Diaspora Networks Facilitating Migration:** Robust diaspora communities from South and Southeast Asia facilitate the migration process, offering essential support in housing, licensure, and integration. These networks make migration more feasible and less risky by providing social capital in destination countries, reinforcing the pull effect over time.
- **Reputation and Global Demand:** Health professionals from this region, particularly nurses from the Philippines and physicians from India and Sri Lanka, are actively sought due to a global reputation for clinical competence, English proficiency, and resilience. This "brand recognition" creates a self-perpetuating cycle of demand, wherein employers in destination countries develop a preference and build recruitment infrastructure targeted specifically at these cohorts.

4. Implications of International Health Worker Migration

International health worker migration has complex, interconnected implications across health systems, economies, and ethical dimensions associated with the choices of health professionals and policymakers.

4.1 Health System Implications

The emigration of skilled professionals, in most cases, weakens health systems in the source countries, creating workforce shortages through "brain drain". This undermines health system capacity through immediate service gaps, particularly in specialised care and rural areas (Cometto et al 2013; Saluja et al 2020). The loss of specialists can be particularly acute, especially in smaller countries like Sri Lanka and the Philippines, where losing even small numbers of specialists can eliminate entire service lines (Niriella et al., 2025; Jha et al 2025).

A 2020 modelling study arrived at a valuation of US$16 billion in annual costs associated with excess mortality in low and middle-income countries resulting from the large-scale migration of physicians from poor to rich countries (Saluja et al 2020).

Additionally, migration can often exacerbate existing domestic geographic maldistribution, heightening urban-rural disparities.

Conversely, "brain gain" can also occur through circular migration when health workers return with enhanced skills acquired in well-resourced systems. Gomes et al. (2024) document returning professionals introducing evidence-based protocols, quality improvement methodologies, and patient safety practices. However, benefits typically concentrate in urban centres rather than addressing domestic health system needs and deficits (Marcus et al 2014; Thompson and Walton-Roberts 2018).

The Philippines' managed migration program attempts to capture brain gain through structured return mechanisms, though it has been argued that this normalises workforce exportation rather than addressing systemic deficiencies. India's returning doctors similarly contribute more to tertiary care development, benefiting urban elites disproportionately (Kumar P, et al. Indian physician migration patterns. Indian J Med Ethics. 2024;9(1):34-45.).

4.2 Economic Implications

The globalisation of healthcare, technological advancements, and the liberalisation of professional labour markets have contributed to the intensification of inequitable distribution of healthcare workers (Bach 2003; Stilwell et al 2004). Medical education costs in HICs now exceed $300,000 per physician, creating economic incentives for recruiting from LMICs where training costs are substantially lower and often publicly subsidised (Greysen et al 2011; AAMC 2024). The immediate availability of internationally educated health professionals eliminates the 4–7-year educational pipeline for physicians and 3-4 years for nurses in high-income countries, without substantial infrastructure investments in medical schools, teaching hospitals, and faculty development (Mullan 2005; Kingma 2006). Consequently, health systems in countries such as the United Kingdom, Canada, and Australia have developed structural dependencies on internationally trained healthcare workers, with foreign graduates comprising 30-40% of their medical workforce (Lafortune et al 2019; GMC 2025). This model enables HICs to circumvent temporal and financial investments in workforce development while effectively transferring educational costs to resource-constrained nations (Sweileh 2024). This massive transfer of health human resources from resource-constrained to wealthy countries represents what Mensah et al. (2005) termed a "perverse subsidy," whereby nations least capable of bearing such costs effectively subsidise the health systems of the world's wealthiest countries.

Health worker migration can also create conflicting economic correlates that complicate policy choices. Remittances from health workers abroad can constitute significant foreign exchange flows that support household consumption and education. The Philippines, for example, receives $5 billion annually, 2% of GDP (Ratha et al 2015). However, depending on the country context, educational investment losses can outweigh remittances or other cross-border revenue benefits. In Africa, for example, Mills et al. (2011) found that annual training costs exceeded many development aid flows. True costs may also extend beyond training to include productivity losses and foregone health improvements. This was definitely the case in Sri Lanka, where medical education is entirely publicly funded, and the loss of trained professionals was considered a hit to domestic finance as well as weakening the public health service delivery.

Thus, the economic implications flowed through two interlinked market economies – one associated with the education and training of health workers, and the other associated with service delivery, dealing with the deployment of health workers.

4.3 Ethical Implications

Health worker migration also raises fundamental questions of distributive justice. Resource-constrained populations with greater health needs effectively finance care for healthier, wealthier populations, which was viewed by some participants as a form of neocolonialism.

Migrant rights constitute another ethical dimension. Despite international frameworks affirming freedom of movement, migrant health workers face systematic vulnerabilities:

- Credential devaluation
- Precarious immigration status enabling exploitation
- Discriminatory career advancement barriers
- Family separation through restrictive visa policies

There is also a gender dimension, particularly affecting female nurses, who comprise a large proportion of migrants. The International Migration Stock data (2024) shows that almost half of the migrants of Southeast Asian origin are women (UN 2024). They experience wage gaps, advancement barriers, and "triple burdens" of professional work, household responsibilities, and transnational care obligations. Filipino nurses in the US, for example, have been reported to take up less desirable positions even as they support extended families back home. When families of the migrant health workers also migrate with them, however, there are no recognisable protections for the rights of the families.

The COVID-19 pandemic exposed these contradictions starkly. Migrant workers faced heightened risks as "heroes" in destination countries while source countries managed pandemic responses with depleted workforces. Accelerated recruitment during COVID-19 surges exemplified "pandemic poaching", extending nationalism to human resources. (Stievano et al 2021). Another dimension of pay parity was also brought up through the example of the nurses from Kerala (India) who were recruited by Bhutan at much higher pay compared to domestic workers to overcome its domestic shortage during the pandemic. While this was a short-term crisis-induced migration, issues related to pay disparities between foreign and domestic workers were also raised as a potential concern.

5. Perspectives on Migration from Across the Region

The Asian region presents a complex picture of health workforce dynamics with mixed dependencies that influence the perspectives and corresponding policy priorities that individual countries give to health workforce migration. Table 1 presents the health workforce status in ten select South and Southeast Asian countries based on the latest available data.

Table 1: Health workforce and migration status among South and Southeast Asian countries

Countries	Medical doctors (per 10,000 population) – [Minimum Recommended per WHO – 10] Year for the latest available official data in brackets.	Nursing personnel (per 10,000 population) [Minimum Recommended per WHO – 25] Year for the latest available official data in brackets.	Health Workers' Emigration Status
Bangladesh	7.22 (2023)	5.01 (2023)	Relatively small proportion (~1% of annual graduates) of migrating health workers, with the bulk of recruitment from the Middle East, the UK and North America (Rahman & Khan 2007). Maldives, Japan & Germany in the pipeline. Saudi Arabia and Bangladesh signed an agreement in 2022 to facilitate the recruitment of medical staff (Siddiqui 2024). The Maldives and Bangladesh signed an MoU in 2021 to recruit doctors & nurses (Siddiqui et al 2022).
India	7.23 (2020)	17.2 (2020)	70,539 doctors from India are working in OECD countries, with an emigration rate of 6 percent (Socha-Dietrich and Durmont 2021). Indian born doctors rank top in terms of the number of foreign health workers in OECD countries. 640,000 Indian nurses are working abroad, especially in Gulf countries (Rajan and Nair 2013).
Indonesia	5.24 (2023)	20.43 (2023)	Between 2022 and 2024, the number of nurses Indonesia deployed abroad annually rose from 958 to 1091, with most nurses emigrating to Japan, Germany, Saudi Arabia and Qatar (WHO 2025).
Malaysia	23.41 (2023)	40.54 (2023)	In 2021, 2,581 Malaysian doctors and nurses worked in the UK's NHS, rising to 3,123 by June 2023—a 21% increase ((Jayakumar 2024) 3,021 nurses went overseas in 2024, marking a 24% increase from 2,445 in the previous year (Pfordten 2025). Main destinations were Saudi Arabia, Singapore and the UK.

Nepal	10.11 (2023)	28.28 (2023)	From 2020 to 2023, the number of medical graduates pursuing careers abroad increased nearly 1.5 times from 869 to 2,318 per the Nepal Medical Council.(Karki et al 2024). Destinations include the USA, UK, Maldives, UAE, Australia, India, Germany, etc. Of the total 72,550 registered nurses in Nepal as of July 2025, around 25,000 (~35%) are already working abroad (Karki 2025).
Philippines	7.92 (2021)	42.09 (2021)	11,267 doctors working in OECD countries, emigration rate of 9 percent to OECD countries (Socha-Dietrich and Durmont 2021). The Philippines Department of Health estimated that in 2021, 51% of licensed nurses migrated (Beltran 2023).
Singapore	28.34 (2022)	65.48 (2022)	No data on emigration. In Singapore, international nursing staff make up 20% of the total nursing workforce (Pung et al 2017).
Sri lanka	11.36 (2023)	18.77 (2023)	One-third of the total doctors trained in Sri Lanka are practising in the OECD (Tangcharoensathien et al., 2017).
Thailand	5.41 (2021)	35.72 (2023)	861 Thai-trained doctors working in OECD countries, emigration rate of 2 percent to OECD countries (Socha-Dietrich and Durmont 2021).
Vietnam	11.07 (2021)	11.35 (2016)	More than 10,000 Vietnamese doctors work in OECD countries (Khor 2019).

Source: WHO National Health Workforce Accounts for density of doctors and nursing personnel. For emigration of health workforce, sources are cited within the text.

Smaller countries in early stages of health system development, such as Timor-Leste and the Maldives, highlighted their reliance on foreign health workers, which is facilitated through formal bilateral agreements, reflecting the nature of the power dynamic in such cases. This contrasts sharply with migration to higher-income countries, often in Europe, the US, Australia or the Middle East, where the power dynamic is much more in favour of the destination countries. Donor countries in Asia also have variable perspectives and experiences over time while balancing the various positive and negative implications associated with migration in contextually dependent ways.

Traditionally Philippines viewed the international demand for its nurses as an economic opportunity, gaining from remittances as well as using this demand as a negotiating point in bilateral and multilateral agreements. However, the acute shortage experienced by the country during COVID and the subsequent abrupt ban by the government on emigration of health workers led to serious unrest and the issue becoming a policy priority. The Philippines' government is now looking to balance its economic and healthcare interests through policy options that sustainably reduce workforce emigration. For smaller countries like Bhutan, Nepal and Sri Lanka, even a relatively smaller number of migrating workers can have a large detrimental impact on the overall workforce mix, leading the governments to actively explore ways of mitigating this risk. Equally, there is

recognition of circular migration, albeit with long timeframes, such as Sri Lankan nurses who migrate to the Middle East before returning to their home country, raising questions about net gain/loss and whether such patterns actually serve the national health system needs.

India appears to have begun instituting policies that can facilitate the emigration of Indian nurses, recognising that it produces more nurses than the WHO-recommended requirement. These include the recent World Federation for Medical Education (WFME) accreditation that paves the way for Indian doctors and nurses to practice abroad (PIB 2023). India is also expanding the number of medical colleges to ensure a robust supply of doctors for the domestic health system despite the high rates of emigration. Foreign-trained doctors from select high-income countries also don't require additional local certification, allowing talented foreign-trained doctors to practice freely, especially in private tertiary care hospitals. India is engaged in multiple Joint Working Groups (JWGs) with countries across Asia to discuss health workforce migration. It has sought to work on mutual recognition of accreditation, for example, with Japan, where Indian nurses are often underemployed due to differences in training standards and the absence of mutual recognition agreements (Seshadri 2016).

Indonesia faces significant internal maldistribution and geographic disparities in its domestic health workforce distribution. Still, since the late 2000s, the country has considered emigration as a potential strategy to support the employment of nurses and reap economic benefits from remittances. Following the Philippines' example, the government entered into economic partnership agreements with high-income countries like Japan and Germany to allow Indonesian nurses to migrate to these countries. These migrant health workers are tracked and protected by Law No. 18/2017 that institutes the Indonesian Migrant Workers Protection Agency (*Badan Pelindungan Pekerja Migran Indonesia*, BP2MI) (Gomes et al., 2024).

Countries like Thailand and Vietnam currently don't see very high rates of emigration and therefore do not see it as an urgent policy priority. There are also additional language barriers that prevent easy migration. Singapore and Malaysia, on the other hand, are either recipient countries or serve as training grounds where professionals initially migrate to obtain better skills before eventually emigrating to their final destination countries in either Europe, the US or the Gulf countries. These countries benefit from the trainees and, in return, contribute to the capacity building of the global health workforce. Interestingly, there is also a long-standing example of circular migration within the region where Malaysian doctors are known to train in India before returning home, which was originally formalised through the Melaka Manipal MoU (Komattil & Hande, 2015).

Nearly all countries in the region face domestic imbalances, with shortages typically occurring in economically poorer or politically neglected areas within countries. It is unclear whether the workforce shortage in historically neglected areas would be resolved even without international migration. Policy options thus must also consider how to create better incentives for health professionals to practice in underserved areas, although this is not the focus of this paper.

6. Approaches to Address Migration

6.1 Global Code of Practice on the International Recruitment of Health Personnel

The World Health Organisation in 2010 adopted the Global Code of Practice on the International Recruitment of Health Personnel, a set of guidelines and principles to promote fair migration practice and mitigate potential negative impacts. This code is currently being revised, and several changes have been proposed. An Expert Advisory Group (EAG) was set up to assess the Code's continued relevance and effectiveness. The EAG met several times between June and November 2024 to arrive at an interim report that was submitted to the 156th Executive Board of the WHO and at the 78th World Health Assembly for review by WHO Member States. The EAG determined that the code continued to be relevant in the face of growing international mobility, which also contributed to the interdependency of health systems across the globe. In theory, the Code of Conduct establishes ethical principles that apply both to formal migration governed by bilateral agreements as well as to the informal or private sector-driven migration that is outside the purview of governments. However, the Code is voluntary in nature, without any enforcement capacity, and therefore rendered inapplicable for informal, non-governmental trade in services that likely constitute the majority of cross-border workforce

movement. While the Code helped raise awareness of the issues among stakeholders and improved health workforce data collection, it had several areas that required strengthening. The EAG found the Code wanting in its consideration of passive recruitment from vulnerable countries and measures for care workers, who are growing in importance in the face of ageing populations, especially among the HIC destination countries. The Code was also inadequate in ensuring ethical management of international recruitment, especially during emergencies, as was demonstrated during the pandemic. Also, the Code was not a sufficient instrument to facilitate necessary investments in health systems and workforce in the source countries. To overcome these deficiencies, the EAG recommended specific additions corresponding to the nature and scope of the Code as well as elements to improve sustainability and resilience, such as targeted co-investments, partnerships, and emergency financing modalities.

The government representatives at the regional meeting added nuance and detail to the EAG's findings, pointing out that migration happens through a variety of different pathways, both formal and informal. Government-to-Government pathways are a relatively small proportion of the overall migratory patterns, with a large number of private agreements or informal recruitments that the governments often have no visibility on. Sometimes, professionals may even be recruited to perform roles adjacent to their training, such as doctors being recruited as phlebologists. Representatives from source countries urged that mechanisms of information sharing from destination countries about immigrant health professionals be incorporated within the Code. Participants at the meeting also asked if provisions in the Code could ensure forms of compensation for source countries from destination countries for the educational investment.

In response, it was pointed out that individual governments have the right to control, regulate, and even penalise unregulated migrants. But adopting a regional or collaborative approach can help governments protect the rights of migrants in their destination countries, as well as enabling collective bargaining.

6.2 Regional/South-South Approaches to Address Migration

Regional institutions have been slow to address health workforce issues comprehensively. ASEAN's health initiatives remain limited, while SAARC and BIMSTEC have yet to develop robust health workforce strategies.

The discussion at the regional meeting helped identify two broad purposes of South-South cooperation on international migration from the Asian perspective. The first was to amplify a collective voice in global forums - using collaborative agency and collective bargaining power. The second is to support operational collaboration on initiatives of mutual learning and standard-setting among Southern countries to address transnational HRH challenges, especially in the context of global labour mobility.

A range of regional and bilateral mechanisms are emerging globally to mitigate the adverse effects of health worker migration, improve workforce resilience, and ensure equitable access to care. These include both system-level cooperation and pragmatic, bilateral arrangements that could serve as models for South and Southeast Asia.

Regional Strategies for Collective Action

Several collaborative strategies could be adopted at the regional level to support both health system strengthening and migration management:

- Data Sharing and Transparency: Initiatives like those proposed by Roberts & Bourgeault (2024) advocate for regional data-sharing platforms to track health worker flows and identify shortages. However, enforcement remains challenging due to uneven political commitment and technical capacity across countries.
- Mutual Recognition of Qualifications: Facilitating recognition of credentials can reduce "brain waste" among migrant health workers and help integrate them more effectively into foreign systems. The ASEAN experience with mutual recognition agreements (MRAs), however, points out that MRAs by themselves have limited impact since market demand, emigration, and recruitment policies continue to influence mobility (Te et al 2018).

- Joint Accreditation and Training Standards: Regional bodies could coordinate accreditation processes and standardise training curricula to ensure quality and comparability of professional competencies. International accreditation by agencies like the Joint Commission International (JCI) is highly desired and has been shown to favourably impact quality (Vuohijoki et al., 2025).
- Emergency Regional Workforce Pool: Short-term deployments, such as the recruitment of nurses from Kerala to Bhutan during COVID-19, demonstrate the value of regional surge capacity agreements for emergencies. An evaluation of international deployments demonstrated the added value of workforce augmentation through regional mechanisms like the African Volunteers Health Corps (AVoHC) during disease outbreaks (Nzegwu et al., 2025).
- Collaborative Research on Migration Drivers: South–South cooperation in migration-focused research could generate contextually relevant evidence for policymaking, especially on the sociocultural and economic dimensions of migration.
- Collective Negotiation Mechanisms: While regional blocs like ASEAN have explored collective positions on migration, divergent national interests have historically limited the feasibility of unified negotiating platforms. Coalitions of the willing, however, can be formed to arrive at common negotiating positions at regional or global governance forums.

Bilateral and Multilateral Agreements in Practice

Several countries have already experimented with structured migration programs that aim to balance workforce mobility with health system needs:

- Short-term Deployments: The Philippines has bilateral agreements with Jamaica and Pacific Island Countries (PICs) that allow for time-bound deployments of Filipino nurses to support training and specialist service delivery.
- Training Support Agreements: The Maldives and Thailand have MoUs allowing Thai institutions to support HRH training in the Maldives. Similarly, India has MoUs with Canada and Singapore for the deployment of nurses.
- Exchange and Return Programs: The UK has implemented exchanges with countries like Thailand and Kenya, where training or research investments support health system development in source countries.
- Triple-Win Agreements: Germany's Federal Employment Agency has signed nurse recruitment agreements with India (Kerala), Indonesia, and Mexico. While these programs offer benefits to all parties, concerns remain about bureaucratic hurdles and power asymmetries between donor and recipient countries (Vogt 2018).
- Dual-Track Domestic-International Planning: Singapore and Malaysia have structured programs combining domestic workforce protection with controlled health worker inflows through scholarships with return service clauses, bilateral agreements for temporary exchanges, and specialist training tracks.

National-Level Policy Options

Countries such as the Philippines and Thailand offer insights into how national-level strategies can mitigate the negative consequences of migration:

- Mission-Critical Skill Identification: Governments should define and protect priority cadres (e.g., emergency physicians, anaesthesiologists) through targeted incentives and policy protections.
- Redesign of Health Workforce Models: Moving away from doctor-centric service models towards multi-disciplinary teams, including community health workers (CHWs), can reduce system reliance on professionals most prone to migration.
- Localised Training and Placement: Thailand's model of community-based training, conducted in local languages and accompanied by mandatory service in home regions, has shown success in improving rural retention, particularly among nurses and allied cadres.
- Professional Development Investments: Sustained investments in education, mentorship, and clinical training pathways are critical to strengthening domestic HRH capacity and reducing push factors.

7. Governance, Rights, and Regulation in Health Worker Migration

The international migration of health workers is not only a matter of workforce supply and demand; it is intrinsically tied to rights, governance, and accountability.

Despite growing recognition of the health workforce as a mobile and global entity, migrant professionals continue to face significant barriers in credential recognition, employment transition, and social integration. Health professionals with foreign qualifications often face long and opaque processes for local certification, which delay their ability to practice and increase vulnerability to informal employment or exploitation. Transition support must include orientation to local health systems, legal rights, labour protections, and cultural competencies. Crucially, families of migrant workers, especially in long-term or permanent migration, need access to education, health care, and social protections to ensure overall wellbeing.

The UCL–Lancet Commission on Migration and Health (2018) offered a framework for addressing these gaps. It emphasised the *shared responsibility* of source, transit, and destination countries to protect the health and rights of migrants and their families. The Commission's call for universal health coverage, portable benefits, and inclusive social protection is particularly relevant in the context of international health worker migration. However, its recommendations remain under-integrated into workforce-specific migration policies, and more deliberate alignment is needed at the regional and global levels.

One paradox for policymakers is that well-intentioned and necessary efforts to raise the quality of health professional education in LMICs (such as through accreditation, international curricula, and alignment with global standards) have inadvertently facilitated migration by making professionals more "export-ready." Nonetheless, improving educational standards remains essential for building resilient local health systems. Governments and academic institutions are therefore forced to pursue a dual mandate - producing globally competent professionals while building incentives, infrastructure, and career pathways that encourage retention within the local health sector.

Regulation, Malpractice, and Accountability

One of the most technically complex regulatory challenges lies in determining the appropriate scope of practice for migrant health professionals. Qualifications obtained abroad may not fully align with the clinical responsibilities defined in the destination country's health system, leading to either underutilisation or inappropriate task allocation.

To address this, destination countries must:

- Establish transparent equivalency frameworks for foreign credentials, with defined pathways for bridging or upskilling where needed.
- Implement probationary licensing periods with supervised practice to assess clinical competence and system familiarity.
- Enable progressive licensure schemes, where migrant professionals can expand their scope of practice as they gain local experience and complete necessary assessments.

Without these systems in place, both health workers and patients may be put at risk - either through unsafe practice or unnecessary barriers to workforce participation.

As cross-border mobility of health workers becomes more formalised through bilateral agreements and global recruitment strategies, pressing questions arise about regulatory jurisdiction and accountability. Who is responsible if a migrant health worker is involved in a malpractice incident? Conversely, what protections are in place if a migrant professional is subject to fraud, abuse, or contract violation, especially under short-term deployments or temporary licensure schemes?

There is currently a lack of coherent regulatory frameworks that clearly define the roles of sending and receiving governments, recruitment intermediaries, and individual professionals. In many cases, migrant workers fall into regulatory grey zones, particularly when deployed under non-standard arrangements (e.g., bilateral exchange programs, aid deployments, or private recruitment).

To ensure accountability:

- Bilateral and multilateral agreements must include clear clauses on malpractice liability, grievance redressal, and legal recourse mechanisms.
- Host countries must define the scope of practice for foreign-trained health workers, specifying whether and how their training aligns with national licensure and practice laws.
- Regulatory bodies must collaborate across borders to ensure reciprocity, standardisation of oversight, and shared disciplinary mechanisms.
- Health workers must have access to independent arbitration or legal aid in case of disputes, especially those involving licensing, employment contracts, or professional misconduct allegations.

8. Conclusion

The dynamics of the health workforce in South and Southeast Asia present a complex interplay of interdependence, opportunity, and vulnerability. Countries such as India, Sri Lanka and the Philippines have emerged as major exporters of health professionals, while striving to meet the evolving needs of their own health systems. The region encompasses a broad spectrum of experiences - from countries in crisis due to workforce emigration, like Sri Lanka, to those with institutionalised export models like the Philippines; from relatively self-sufficient systems in Indonesia and Vietnam, to strategic importers such as Thailand and Singapore. This diversity underscores the need for differentiated context-specific policy approaches rather than one-size-fits-all solutions.

As global health systems face mounting pressures, ensuring an equitable distribution of health workers, both within and across countries, has become an urgent priority. It is essential not only for achieving universal health coverage but also for advancing regional and global health security. However, current patterns of health worker migration often reflect deeper structural inequities in global health governance. While the right to mobility must be upheld, the prevailing dynamic where professionals migrate from under-resourced to well-resourced systems frequently results in regressive flows that exacerbate disparities and undermine the goals of health equity and sustainable development. Reversing this trend requires a collective reimagining of the health workforce as a global public good that demands shared investment, coordinated governance, and mutual accountability.

While several countries in the region are exploring collaborative models, most initiatives remain fragmented, driven by bilateral arrangements, informal networks, or short-term need. There is a clear and pressing need to strengthen cross-border coordination, particularly through regional platforms such as ASEAN and BIMSTEC. These forums offer promising avenues for policy harmonisation, joint planning, and crisis preparedness.

Key recommendations that emerged from the regional meeting include:

- Mapping and monitoring cross-border health workforce flows
- Enhancing data sharing on training, deployment, and migration
- Advancing ethical recruitment practices grounded in global norms
- Developing regional emergency preparedness frameworks that are rooted in solidarity and mutual aid.

The experiences of South and Southeast Asia emphasise the importance of integrated, multi-level governance of health workforce mobility. While national-level retention strategies remain vital, sustainable solutions must go further by combining:

- Rights-based and ethical migration frameworks
- Investment in domestic education, training, and working conditions
- Regional cooperation on standards, accreditation, and surge capacity, and
- Strategic bilateral partnerships that deliver mutual benefit and uphold health equity.

Given the shared vulnerabilities exposed by recent global health emergencies, the region is well-positioned to lead globally relevant innovations in health workforce governance. By aligning health worker mobility with broader health system resilience strategies, South and Southeast Asia can contribute not only to their own sustainable development, but also to a fairer, more balanced global health order.

Sri Lanka Case Study

(Developed by Dr. H.M.A.C.B. Herath & Dr. Lahiru Kodithuwakku)

Sri Lanka's health system comprises an extensive network of curative and preventive sector institutions spread across the country. The state health sector plays a dominant role and handles 95% of the total inpatient admissions and 50% of the outpatient admissions, providing free curative and preventative health care services. As of 2022, the country had over 1500 healthcare institutions and 353 public health institutions, catering to a population of 22 million Sri Lankans (Ministry of Health, Sri Lanka, 2023).

Sri Lanka's state health system is entirely funded through taxpayer contributions. Healthcare expenditure as a percentage of GDP is 4.36, and healthcare expenditure per capita is 145.5 USD in 2022. However, the Out-of-Pocket Expenditure Per Capita remains as high as 40.2 USD in 2022 (World Bank Open Data, n.d.). Despite the challenges, Sri Lanka has achieved good health indicators in Maternal and Child Health Immunisation and elimination of communicable diseases compared to other regional countries (Agampodi et al., 2021; Gamage et al., 2021; Family Health Bureau, 2025).

Health Work Force as a strong Health System Pillar

Sri Lanka's health system is powered by a competent workforce of approximately 150, 000 staff across 250 occupational categories (De Silva, 2025). According to the Annual Health Bulletin 2022-2023, this includes 23,999 medical officers, 1,604 dental surgeons, 53,283 nurses, 2,230 Public Health Inspectors, and 9,059 midwives (Ministry of Health, Sri Lanka). According to the health statistics of 2021, Sri Lanka had 1.2 doctors and 2.4 nurses and midwives per 1000 population. By 2022, apart from the state cadre of doctors, an estimated 1,500 doctors are engaged in full-time private sector practice in Sri Lanka, serving as general medical practitioners or employees in private hospitals. Additionally, around 320 medically qualified personnel are employed by defence establishments, while approximately 760 doctors serve in the permanent academic cadre of universities (De Silva, 2025). Sri Lanka's health system, with its inherent constraints on finances and infrastructure development, has always relied on the skilled health workforce to deliver and sustain its impressive health indicators.

Investment in health workforce

Sri Lankans enjoy a free education system from primary education to undergraduate education in universities, funded by the taxpayer (Alawattegam, 2020). Medical officer training typically spans 6-7 years, while specialist doctors require 7-10 years of specialised education (Advice.lk, n.d.). Nursing professionals must complete either a nursing degree program (usually four to five years) or a diploma program (usually three years), all offered to qualify secondary school graduates without tuition fees (Jayasekara & Amarasekara, 2015a). In addition to this, all other healthcare staff also receive necessary training free of charge across various levels under the state education and health systems.

According to the statistics of the University Grants Commission, taxpayer spends around 5.5 million rupees to produce a medical doctor and 8.6 million rupees for a dental surgeon (De Silva, 2025). This contribution extends to the mandatory foreign placement of medical specialists for one year as part of their specialised training, where taxpayers pay for the daily living subsistence and travel costs at the destination. Following the training, they are expected to return, and a bond is signed between the GoSL and the trainee for their return. However, there is no specified mandatory service requirement for the trainee post their overseas training (De Silva et al., 2013).

To date, all medical graduates from state medical colleges and medical graduates who qualify for a licensing exam following overseas undergraduate training are absorbed into the state health system. Once absorbed, medical officers have the highest starting salary, fastest salary progression, and the highest maximum wage among health professions in the region (World Health Organisation, 2018).

For nurses and midwives practising in the state health care system, education is done through taxpayer-funded training programs in 18 nursing schools around the country (S. Jayasekara & D. Amarasekara, 2015). Most nurses follow a three-year training program directly in the state health care system, while a minority attend university (S. Jayasekara & D. Amarasekara, 2015). Based on the perceived need of the central ministry institutions and provincial institutions, nurses are recruited into state service.

Economic crisis and implications for health workforce

In early 2022, Sri Lanka only had USD 2.31 billion in foreign reserves, whereas its debt payments for 2022 stood at USD 4 billion. Public debt reached USD 83.6 billion by the end of 2022, with reserves hitting a meagre $1.93 billion by March 2023, amidst impending foreign debt obligations. The crisis caused a record 7.8% GDP contraction in 2022, significantly increased household expenditure, and led to country-wide shortages of fuel, food, and medicine. The rate of inflation was at an all-time high of 50% a year (Samarakoon, 2024).

The health sector was among the worst-hit sectors. Apart from a generalised scarcity of medicinal drugs, healthcare access was also affected by transport disruptions and high inflation. According to the Household Survey on Impact of Economic Crisis in 2023, around 7 % of patients changed their treatment procedures as a direct result of the economic crisis. Among patients who changed their treatment procedures, a significant majority (81.7%) reported insufficient funds as the primary reason for the change (Department of Census and Statistics, 2023). Skilled health workforce, including doctors and nurses, migrated to other countries to escape the economic hardships prevailing in the country. (Niriella, 2025). Sri Lanka's Minister of Health, Dr. Nalinda Jayatissa, made a statement at the seventy-eighth World Health Assembly (WHA78) of the World Health Organisation (WHO) in Geneva, Switzerland, that between 2022 and 2025, more than 4,600 healthcare professionals migrated overseas. This number includes 726 specialist consultants, 1,116 medical officers, and nearly 2,800 nursing officers.

Sri Lanka Medical Council (SLMC), the statutory body responsible for registering all Western medical practitioners in the country, recorded 33,284 active registrations in December 2022. However, only about 77% of these registered doctors are actively practising within Sri Lanka. The remaining 23% are believed to be either working overseas or retired from active service (De Silva et al., 2023). Niriella and others estimate that approximately 1,489 doctors, including specialists, migrated from Sri Lanka between 2022 and 2024. The economic loss for the country is estimated to be approximately LKR 12.5 billion (USD 41.5 million) (Niriella, 2025).

Although the trend has slowed down following relative economic stability in 2024 and 2025, the high taxation of professionals introduced to increase government revenue is further distancing doctors from the country. According to the latest data, total tax revenue increased significantly in 2024, reaching an estimated Rs. 3,708.6 billion by the end of August, representing a 30% or higher increase from the previous year. (Public Finance. LK, n.d.). This increase includes taxation for services provided by the doctors, including Payee Tax for their state service, and Value Added Taxes and Income Taxes for their income generated through private practice. However, for the professionals who pay under the highest income tax brackets, there are no earmarked benefits, unlike in other countries, and no clear information on how this taxpayer money is spent, creating further ambivalence.

Factors influencing the migration of skilled health care workers

Although Sri Lanka also experiences similar push and pull factors influencing health workforce migration like their South and Southeast Asian neighbours, some unique characteristics are noteworthy.

a. Cost of Living and Skeletal Salary Structures

Fallout from the economic crisis had a direct impact on the middle and upper middle-income cohorts in the country, including junior and mid-career doctors and nurses. Research shows that during the crisis, 65% of households have seen their monthly average income decrease. Around 91.0% of households experienced an increase in their total household average monthly expenditure, and 22% of households are indebted (Department of Census and Statistics, n.d.).

Compared to countries in the region, doctors and nurses get a below-par salary in the state health sector. Basic salaries remain grossly inadequate, compensated by allowances, which are subject to regulations and policy changes by the incumbent government. Hence, the salary regime remains structurally unstable and subject to overall economic shocks. Doctors and nurses often try to compensate by doing extra duty and working on public holidays, yet payments for such extra work remain consistently low (The Morning, 2025a; Senasinghe & Sachitra, 2020).

b. High Taxation

Income of the professional categories, including doctors and nurses, was already under the payee tax scheme. However, with the tax reforms following the IMF debt restructuring programme, all sources of income have been brought under the income tax ambit, leading to a significant reduction in monthly incomes, especially affecting junior and mid-career level doctors who use private practice as General Practitioners to supplement their low wages in the state sector (Silva et al., 2024).

c. Work Burden and Burnout

Sri Lanka has a no-turn-down policy on patient admissions and a poor referral system. Doctors and nurses are thus often asked to look after patient numbers exceeding their due routine by three to four times, creating fatigue and burnout (Desapriya et al., 2023). Additionally, doctors, particularly specialists, are asked to cover up for other hospitals where there is a cadre insufficiency, without extra pay, transport, or accommodation facilities provided. Midwives and public health inspectors usually cover multiple areas, often in difficult terrain in remote areas (Prabath et al., 2022; Senevirathne et al., 2024)

d. Transfer schemes

Through the government transfer schemes, health workers can often be posted in places where there is no requirement for their specific skill set and hence asked to cover other duties (De Silva, 2025). Once a professional has acquired a specific specialised skill (e.g, surgical skills), there is no regulation to retain them in that particular unit. Instead, rules require them to be transferred after completion of four years in the unit. Discussions to address these counterproductive transfer rules have been stalled due to trade union pressure and government lethargy (The Morning, 2025b).

e. Changing public perception

Trade union actions by doctors have resulted in popular anger among the public against doctors, with public interest groups calling for curbs on the rights of healthcare workers to migrate. There is an ongoing discourse regarding the patients' rights and doctors' right to protest, which has given rise to counterattacks on popular media from both sides (CEPA, n.d.). Although the barriers and challenges faced by the health care staff are real and require urgent and sustainable solutions, the debate on migration has overshadowed the entire discourse.

Conclusion

With the recent change of government and the re-emergence of left-leaning political thought within the political landscape in Sri Lanka, the discourse on health worker migration has again come into the limelight. Multiple parties, including trade unions and professional association,s have come up with their own recommendations and suggestions for a win-win deal, both for health workers and the public. Some of which include:

a. Allowing health care workers to work outside the country for a shorter period of time with leave, similar to sabbatical leave in the university sector.

b. Improved enforcement of bonds for doctors and nurses, particularly for taxpayer-funded higher education/ training opportunities overseas

c. Improved working conditions, infrastructure improvements, and flexible work schedules.

d. Incentives towards improving quality of life for professionals on basics like living quarters, schooling for children, and allowances for working in difficult stations (Perera, 2024)

e. Bilateral tax sharing agreements with countries that attract professionals (Niriella, 2025)

Sri Lanka's case study on migration of healthcare workers and its impact on the health system, highlights the dilemmas faced by policy makers in finding a solution that can be accepted by all parties involved. Balancing the long-term investment through taxpayer money versus the individual rights of professionals won't be an easy task. Perhaps, a region-wide consensus on the issue, while appreciating the uniqueness of country contexts, could be the way forward, facilitating a unified global south voice against the brain drain.

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